This presentation is for illustrative and general educational purposes only and is not intended to substitute for the official MSHA Investigation Report analysis nor is it intended to provide the sole foundation, if any, for any related enforcement actions.

## Coal Mine Fatal Accident 2005-05



Operator: Consolidation Coal Company

Mine: Shoemaker Mine

Accident Date: May 11, 2005

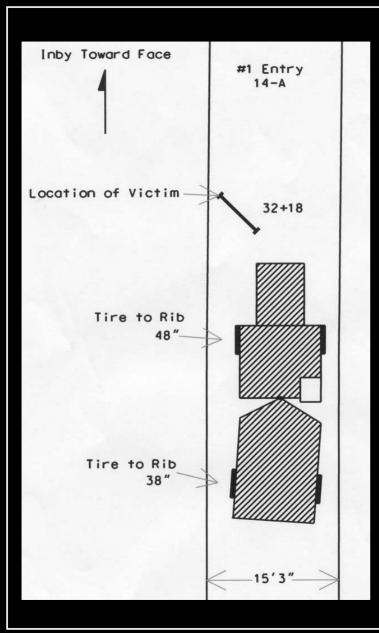
Classification: Powered Haulage

Location: Dist. 3, Marshall County, WV

Mine Type: Underground

Employment: 429

Production: 16,365 tons/day



On Wednesday, May 11, 2005, at approximately 1:30 p.m., a 47-year old timberman, with 3 years and 24 weeks mining experience, 1 year and 12 weeks at the mine, was fatally injured when he was struck by a battery powered scoop.

The scoop was equipped with a "duck bill" attachment and loaded with wedging materials. The victim was last seen by the scoop operator walking approximately 5-6' ahead of the scoop in the left front area. Just before the accident, the scoop operator looked away from the victim to examine the right coal rib. The victim was crushed and fatally injured beneath the "duck bill" of the scoop.

The accident occurred because the operator's comprehensive mine safety program did not ensure that persons remained clear of moving mobile rubber tire equipment. The victim was in an unsafe location while walking in the No. 1 entry to the work site. The operator of the scoop did not assure that the victim was positioned in a safe distance from the scoop.



The photo above shows the view from the operator's compartment toward the victim's location. Only the cap lamp of a person, standing at the victim's location (indicated by the yellow ellipse), was clearly visible from this view.

## **ROOT CAUSE ANALYSIS**

<u>Causal Factor</u>: Procedures, rules, or policies within the operator's comprehensive mine safety program did not ensure that persons remained clear of moving mobile rubber tire equipment.

Corrective Action: Mine management modified their comprehensive mine safety program to address the safe location of persons in the vicinity of operating mobile rubber tire equipment. All underground personnel were reinstructed regarding the safe location of persons around operating mobile rubber tire equipment. Management should routinely observe work habits and monitor enforcement of the newly established policies in the comprehensive mine safety program.

## **ENFORCEMENT ACTION**

A 314(b) Notice to Provide Safeguard was issued to Consolidation Coal Company. On May 11, 2005, a miner was fatally injured while working in close proximity to a scoop. The scoop was not operated in a manner which would provide for the safety of persons working in close proximity.

## **BEST PRACTICES**

- Remain a safe distance from moving equipment until it has passed.
- Walk behind moving mobile equipment when traveling in the same entry.
- When operating mobile equipment, ensure that other workers are in a safe area before moving the equipment.
- When necessary to walk or work in the area of moving mobile equipment, wear reflective clothing to ensure a high visibility.